DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/08/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445207	A. BUILDING _____ B. WING _____	02/29/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEXFORD HOUSE, THE	2421 JOHN B DENNIS HIGHWAY KINGSPORT, TN 37660

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The annual recertification survey and complaint investigations of Complaint #'s 28620 and 28726 were completed onsite February 29, 2012. No deficiencies were cited related to the complaints under 42 CFR 483.13, Requirements for Long Term Care.	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update	F 157	1. Resident #1 who was identified during survey as having the wrong Foley catheter sized 18/30cc placed in their urinary bladder when it was ordered by the MD as a 16/5cc, had an order obtained from physician for Foley catheter size 18/30cc on 2/28/12. 2. All other residents who have Foley catheters in their urinary bladder had their Foleys checked for correct size per the physician orders on 2/29/12. 3. A systematic approach to ensure that all residents who have physician orders for a Foley catheter get the correct size will have their Foley catheter audited on a monthly basis by the Quality Assurance Nurse and documented on an audit tool. All Unit Managers and Medication Nurses will receive in-service education on placing the correct Foley size per the physician order. 4. Monitoring of correct Foley catheter size per physician orders will be monitored per a Foley Catheter Audit tool by the Quality Assurance Nurse and compliance reported monthly at the Quality Assurance meeting.	April 9, 2012

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kathy K. Green / Kathy Green	RN DON	3/21/2012

any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 157	Continued From page 1 the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to notify the physician prior to increasing the indwelling catheter size for one (#1) of thirty sampled residents. The findings included: Resident #1 was admitted to the facility on April 15, 2011, with diagnoses including Pressure Ulcer, Dysphagia, Senile Dementia, and Diabetes. Medical record review revealed a physician's order dated December 14, 2011, to insert an indwelling catheter to prevent contamination of an open wound. Medical record review of a Nurse's Notes dated December 14, 2011, revealed a 16/5cc (cubic centimeter) indwelling catheter was inserted as ordered. Continued medical record review of a Nurse's Note dated January 6, 2012, revealed the catheter came out during care and was replaced with an 18/10cc indwelling catheter. Further medical record review of a Nurse's Note dated January 7, 2012, revealed "...catheter was replaced d/t (due to) not draining...replaced with 18/30cc." Medical record review revealed no documentation the physician had been notified when the catheter size had been increased.	F 157		

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F 157	Continued From page 2 Observation with LPN (Licensed Practical Nurse) #3 in the resident's room, on February 27, 2012, at 12:30 p.m., revealed the resident had an 18/30 cc Indwelling catheter inserted. Interview at that time confirmed the physician had not been notified of the catheter size increase.	F 157		
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and Interview the facility failed to assess and obtain signed consent for the use of bilateral three quarter side rails for one resident (#11) of thirty residents reviewed. The findings included: Resident #11 was admitted to the facility on January 17, 2012, with diagnoses including Muscle Weakness, Paralysis Agitans (Parkinson's Disease), Congestive Heart Failure, Generalized Anxiety Disorder, Anemia, Cardiac Pacemaker, and Vascular Dementia. Medical record review of the Minimum Data Set (MDS) dated January 22, 2012, revealed the resident had severe cognitive impairment, required extensive assistance with activities of daily living, and ambulated with a walker and	F 221	1. Resident #11 who was identified during survey as not having a consent signed for ¾ Side Rails, which were present for mobility-to assist resident with getting out of bed, had the Side Rails removed and resident was placed in a low bed on 2/28/12. This change will allow her to get out of bed at will. 2. All other residents who have Side Rails had their medical record reviewed to ensure that a consent was signed by the resident and/or POA allowing the side rails to be in place along with the reason for their presence. 3. A systematic approach to ensure that all residents who have Side Rails have a consent in place will have their Side Rails audited on a monthly basis by the Unit Manager or Quality Assurance Nurse and documented on an audit tool. All Unit Managers and the Incident & Accident Nurse will have in-service education on obtaining a signed consent for any side rail along with the reason documented for side rail implementation. 4. Consent for Side Rails will be monitored per a Restraint Audit tool by the Quality Assurance Nurse and compliance reported monthly at the Quality Assurance meeting.	April 9, 2012

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F 221	Continued From page 3 assistance of one person. Medical record review of the nurse's notes and interview with the Falls and Incident Coordinator confirmed the resident had no falls or injuries at the facility since admission. Observation on February 27, 2012, at 5:40 a.m., in the resident's room, revealed the resident sitting up at the foot of the bed, "...I'm about to get up to...(go to the bathroom)." Further observation revealed the three quarter side rails were up on both sides of the bed and staff were not in the room to assist. Observation and interview in the resident's room on February 27, 2012, at 5:45 a.m., with Licensed Practical Nurse #12, confirmed the side rails were up on both sides of the bed and the resident was trying to get out of the bed. Interview with Director of Nursing (DON) on February 27, 2012, at 8:55 a.m., in the Executive Conference Room, confirmed the resident's exiting the bed at the foot with bilateral raised side rails was not a normal way for the resident to get out of bed and the side rails were preventing the resident's normal exit from the bed. Interview with the Falls and Incident Coordinator on February 27, 2012, at 9:00 a.m., in the Executive Conference Room, confirmed a restraint assessment had not been completed and a consent for the use of side rails had not been obtained.	F 221		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES	F 246	1. It was noted during survey on 2/27/12 that Resident #15 had a 42" bariatric air mattress in place, which had a "gap"	April 9, 2012

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F 246	Continued From page 4 A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to ensure appropriate equipment was in place for one resident (#15) of thirty resident's reviewed. The findings included: Resident #15 was admitted to the facility on August 25, 2009, with diagnoses including Vascular Dementia with Delusions, Senile Dementia, Osteoarthritis, and Diabetes with Neuro Manifests. Medical record review of the Minimum Data Set (MDS), dated February 7, 2012, revealed the resident was severely cognitive impaired and required extensive assistance with toileting, dressing and transfers. Observation on February 27, 2012, at 8:30 a.m. and 12:00 p.m., in the resident's room, revealed the resident lying in a bariatric bed with an air mattress in place. Further observation revealed there was a space between the air mattress and the bedrail on the left side of the bed and the air mattress pad was against the rail on the right side of the bed.	F 246	Cont. between the left side bedrail and mattress measuring 5.5" which is above the required limit of 4.6". This air mattress was replaced on 2/27/12 with a larger mattress measuring at least 48" and did not exceed the gap requirement limit. 2. All other resident's mattresses in the facility were checked to make sure their mattress-side rail gap measurement did not exceed the 4.6" required limit on 2/27/12. 3. A systematic approach to ensure that all resident's mattresses do not exceed the 4.6" mattress-side rail gap requirement limit will be audited on a monthly basis by the Quality Assurance Nurse or Unit Manager and documented on an audit log. All Unit Managers, Medication Nurses, Nursing SV's. C.N.A. SV, C.N.A.'s and the Quality Assurance Nurses will receive in-service education on the mattress-side rail gap requirement. 4. Monitoring of mattress-side rail gap requirement limit will be monitored per a Mattress-Side Rail Gap Audit Log by the Quality Assurance Nurse and compliance reported monthly at the Quality Assurance meeting.	April 9, 2012

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F 246	Continued From page 5 Interview with Unit Manager #5, on February 27, 2012, at 8:45 a.m., in the 500 Wing hallway, revealed "the resident does not get up without assistance and is very reluctant to get out of the bed." Observation and interview with Maintenance Employee #1, on February 27, 2012, at 12:55 p.m., in the resident's room, revealed the following measurements: a 5.5" (inch) gap between the resident's air mattress and the side rail on the left side of the bed. Further interview confirmed the resident's bed was a bariatric bed (48") and the air mattress pad was a 42" air mattress. Observation and interview with the Quality Assurance Coordinator, on February 28, 2012, at 8:00 a.m., in the resident's room, confirmed a 5.5" gap between the air mattress and the bedrail on the left side. Further interview confirmed the air mattress should be a 48" air mattress pad. Observation and interview with the Administrator on February 28, 2012, at 8:20 a.m., in the resident's room, confirmed the 5.5" gap between the air mattress and the bedrail and the 42" air mattress was not appropriate for the bariatric bed.	F 246		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care	F 279	1. Resident #2 who did not have his Tube Feeding and PICC Line D/C'ed on the Care Plan, had this D/C information documented on the Care Plan on 2/29/12. Cont.	April 9, 2012

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F 279	Continued From page 6 plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on medical record review and interview the facility failed to revise a comprehensive care plan for one resident (#2) of thirty residents reviewed. The findings included: Resident #2 was admitted to the facility on August 15, 2011, with diagnoses including Pressure Ulcer, Pneumonia, Anxiety Disorder, and Quadriplegia. Medical record review of a Physician Order dated February 1, 2012, revealed "...D/C (discontinue) PICC (peripherally inserted central catheter)..." Continued medical record review of a Physician Order dated January 27, 2012, revealed "...D/C tube feeding..."	F 279	cont. 2. All other residents in the facility who have a Tube Feeding and/or PICC Line D/C'ed had this D/C information documented on their Care Plan as well. 3. A systematic approach to ensure that all residents who have a Tube Feedings and/or PICC Line D/C'ed on their Care Plan, will have any D/C information assessed for completeness each month by the Unit Manager or Quality Assurance Nurse and documented on a Tube Feeding or PICC Line audit tool. All Unit Managers and Quality Assurance Staff will have in-service education on the requirement to document the D/C date of all Tube Feedings and PICC Lines on the resident's Care Plan. 4. Monitoring to ensure compliance of the Tube Feeding and PICC Line D/C dates on the resident's Care Plan will be monitored per the Tube Feeding and PICC Line Audit tool by the Quality Assurance Nurse and reported monthly at the Quality Assurance meeting.	April 9, 2012

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F 279	Continued From page 7 Medical record review of the resident plan of care updated January 4, 2012, revealed "...PICC line...Jevity (type of tube feeding)..." Interview with the Minimal Data Set (MDS) Coordinator #1 and Licensed Practical Nurse (LPN) #7 on February 28, 2012, at 10:07 a.m., at the 500 hall nurse's station confirmed the PICC line and the feeding tube had been discontinued. Continued interview at this time confirmed the facility failed to revise the care plan to reflect the changes.	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced	F 280	1. Resident #1 who did not have Foley catheter insertion on the Care Plan, had this information documented on the Care Plan on 2/29/12. 2. All other residents in the facility who have a Foley catheter insertion had this information documented on their Care Plan as well. 3. A systematic approach to ensure that all residents who have a Foley catheter insertion documented on their Care Plan, will have this information assessed for completeness each month by the Unit Manager or Quality Assurance Nurse and documented on a Foley catheter audit tool. All Unit Managers and Quality Assurance Staff will have in-service education on the requirement to document the Foley Catheter insertion on the resident's Care Plan. 4. Monitoring to ensure compliance of the Foley Catheter insertion are documented on the resident's Care Plan will be monitored per the Foley Catheter Audit tool by the Quality Assurance Nurse and reported monthly at the Quality Assurance meeting.	April 9, 2012

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F 280	Continued From page 8 by: Based on medical record review and interview, the facility failed to revise the careplan for one resident (#1) of thirty residents reviewed. The findings included: Resident #1 was admitted to the facility on April 15, 2011, with diagnoses including Pressure Ulcer, Dysphagia, Senile Dementia, and Diabetes. Medical record review of a Nurse's Note revealed an indwelling catheter was inserted on December 14, 2011, to prevent contamination of the open wound. Medical record review of the resident's plan of care dated February 14, 2012, revealed the care plan had not been revised to reflect the indwelling catheter. Interview with the MDS (Minimum Data Set) Coordinator in the MDS office, on February 27, 2012, at 12:45 p.m., confirmed the facility had failed to revise the care plan to reflect the use of the indwelling catheter.	F 280		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and Interview, the facility failed to label an	F 281	1. Resident #4 who had IV Medication infusing at the bedside with no additional labeling to show right resident, right medication, right route, right dose, and right time on the front of the bag during survey had this information added on 2/29/12. Cont.	April 9, 2012

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F 281	Continued From page 9 intravenous antibiotic for administration for one resident (#4) of thirty residents reviewed. The findings included: Resident #4 was admitted to the facility on December 12, 2011, with diagnoses including Difficulty Walking, Respiratory Abnormalities, Muscle Weakness, Other Orthopedic Aftercare, Diabetes Mellitus, Peripheral Neuropathy, and Osteomyelitis. Medical record review of the Physician's Orders dated February 25, 2012, revealed "...clarification Cipro (Ciprofloaxin, an antibiotic) 200 mg (milligrams) IV (intravenously) BID (two times daily) re (reference) osteomyeitis..." Observation on February 27, 2012, at 5:30 a.m., in the resident's room revealed an IV pole with two empty IV medication bags with manufacturer's labels designating Ciprofloaxin 200 mg in 100 milliliters (ml) of sterile diluent with no additional labeling to show right resident, right medication, right route, right dose, and right time. Interview with LPN #12 on February 27, 2012, at 5:35 a.m., in the resident's room confirmed the medications were not labeled for administration for the resident.	F 281	cont. 2. All other residents in the facility with IV Medication infusing at the bedside also had additional labeling to show right resident, right medication, right route, right dose, and right time on the front of the bag 3. A systematic approach to ensure that all residents who receive IV Medication have additional labeling to show right resident, right medication, right route, right dose, and right time on the front of the bag will be audited on a per case basis by the Unit Manager, House SV, Medication Nurse or Quality Assurance Nurse by documenting it on an IV Medication Log to ensure compliance with the professional standard of quality. All Medication Nurses, Unit Managers, and Quality Assurance Nurses will be in-serviced on the requirement to ensure that there is additional labeling on the IV medication bag to show right resident, right medication, right route, right dose, and right time on the front of the bag. 4. Monitoring to ensure all IV Medication information has the right resident, right medication, right route, right dose, and right time on the front of the bag will be monitored for compliance by auditing the IV Medications on an individual basis by the Unit Manager, House SV, Medication Nurse and/or Quality Assurance Nurse who will report results to the monthly Quality Assurance meeting.	April 9, 2012
F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea,	F 322	1. Residents #13 and #14 who did not have Tube Feeding Start Times on the Tube Feeding bag, had this information documented on the bag on 2/29/12. Cont.	April 9, 2012

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F 322	Continued From page 10 vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and interview the facility failed to ensure tube feedings were properly labeled for two residents (#13 and #19) of thirty residents reviewed. The findings included: Resident #13 was admitted to the facility on January 24, 2012, with diagnoses including Brain Stem Cerebrovascular Accident, Respiratory Failure, and Diabetes Mellitus. Observation on February 28, 2012, at 7:33 a.m., revealed the resident lying in the bed with Glucerna 1.2 (specialized tube feeding) infusing at 75 ml (milliliters) per hour per the Percutaneuous Endoscopic Gastrostomy (PEG) feeding tube and did not have a start time. Review of the facility policy, Gastric Tube Feeding via Mechanical Pump, revised May 2009, revealed, "...pour prescribed...date, time, label bag..." Interview with Licensed Practical Nurse #7 on February 28, 2012, at 7:48 a.m., in the resident's room confirmed the tube feeding was not timed. Resident #14 was admitted to the facility on January 12, 2012, with diagnoses including: Dementia with Delirium, Chronic Kidney Disease,	F 322	cont. 2. All other residents who have Tube Feedings in the facility also had their Tube Feeding Start Times documented on their bag as to what time it was started. 3. A systematic approach to ensure that all residents who have Tube Feedings will have the Start Time documented on their Tube Feeding bag by auditing each tube feeding on a weekly basis on a an audit log by the Medication Nurse, Unit Manager or Quality Assurance Nurse. All Medication Nurses, Unit Managers and Quality Assurance Nurses will have in-service education on the requirement to document the Start Time of the tube feeding on the bag. 4. Monitoring to ensure compliance of the tube feeding Start Time on the bag will be done per the Tube Feeding Start Time Audit Log by the Quality Assurance Nurse and reported monthly at the Quality Assurance meeting.	April 9, 2012

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F 322	Continued From page 11 Cardiomyopathies, prior Cardiac Arrest, Acute Myocardial Infarction, Chronic Respiratory Failure, Ventilator Weaning, and Anoxic Brain Damage. Medical record review of the Minimum Data Set (MDS), dated January 18, 2012, revealed resident #14 had severely impaired cognitive skills, required continuous oxygen therapy and tube feedings. Observation on February 28, 2012, at 12:45 p.m., in the resident's room, revealed the tube feedings (Glucerna 1.2) infusing at 80 millliters (ml) per hour and the label on the tube feeding bag had no time as to when the Glucerna was started. Interview with Unit Manager #6, on February 28, 2012, at 12:45 p.m., in the resident's room, confirmed the facility failed to place the time on the label and did not follow facility policy.	F 322		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, review of facility policy, and interview, the facility failed to ensure a safety device was activated for	F 323	1. Residents #8, #9 and #11 who were noted during survey to have had their Pressure Alarm Device not working correctly as related to a recent fall, had their devices checked to ensure they were currently working properly on 2/29/12. 2. All other residents in the facility who have Pressure Alarm Devices had these devices checked on 2/29/12 for proper function. Cont.	April 9, 2012

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F 323	Continued From page 12 three residents (#8, #9, #11) of thirty residents reviewed. The findings included: Resident #8 was admitted to the facility on November 15, 2011, with diagnoses including Vascular Dementia with Depressed Mood and Delusions, Paralysis Agitans, Atrial Fibrillation, Dementia with Behavioral Disturbance, Diabetes, Chronic Obstructive Pulmonary Disease, Obstructive Sleep Apnea, Hypertension, Morbid Obesity, and Long-term Anticoagulants. Medical record review of the Nursing Notes revealed the resident had one fall on December 2, 2011, with no injuries. Medical record review of a Nursing Note dated December 7, 2011, at 8:00 p.m., revealed, "Called to room by CNA (Certified Nursing Assistant). Noted resident sitting in floor in front of w/c (wheelchair). Resident states...was trying to go to bed. Abrasion noted to (L) (left) forearm from under elbow to just above wrist. Cleaned and wrapped..." Observation of the resident on February 27, 2012, at 9:20 a.m., February 28, 2012, at 8:50 a.m., and February 29, 2012, at 7:40 a.m., in the resident's room, revealed the resident in bed with a pressure pad alarm and a personal safety clip alarm in place. Review of the facility's policy, Falls Protocols revised April 2009 revealed "...One fall...PSA (Personal Safety Alarm)/Pad if appropriate..."	F 323	Cont. 3. A systematic approach to ensure that all Pressure Alarm Devices are working properly will be accomplished by a weekly audit preformed by the Quality Assurance Nurses or C.N.A. SV's and placed on an audit tool. All C.N.A.'s, Charge Nurses, Medication Nurses and Quality Assurance Nurses will be given in-service education on how to check the Pressure Alarm Devices for proper functioning.. 4. Monitoring to ensure that all the Personal Alarm Devices are being reviewed for proper functioning will be done by placing the monitoring results on an audit tool and compliance reported by the Quality Assurance Nurse at the monthly Quality Assurance meeting.	April 9, 2012

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F 323	Continued From page 13 Review of a facility investigation dated December 7, 2011, revealed the resident had a wheelchair alarm in place on December 7, 2011, which was "not working correctly." Continued review of four investigation statements revealed no mention of the resident having a wheelchair alarm in place or sounding at the time of the fall on December 7, 2011. Interview with the Fall and Accident Coordinator in the Executive Conference Room on February 29, 2012, at 9:55 a.m., confirmed the PSA had not been turned on at the time of the fall on December 7, 2011. Resident # 9 was admitted to the facility on July 28, 2009, with diagnosis of Dysphagia, UTI, Vascular Dementia with Delusions, Depressed Mood, Pain in Soft Tissues of Limb, Dementia with Behavioral Disturbances, General Anxiety Disorder, Senile Dementia, Mood Disorder, Diabetes type II, Gout, Anxiety, Hypoxemia, and Down's Syndrome. Medical record review of the Nursing Notes revealed the resident had four falls between March, 2011 and December 28, 2011, without significant injury. Medical record review of a Nurse's Note dated December 28, 2011, revealed "...Resident in floor beside of bed, vss (vital signs stable) with T (temperature)-98.0, P (pulse)=64, R (respirations) =22, BP (blood pressure)=134/80. No injuries ntd. (noted)@ (at) this time. Res (resident) had pulled Foley tubing loose from drainage bag. Tubing replaced, bed changed, bed alarm activated, res assisted back to bed x's 3 (with the	F 323		

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F 323	Continued From page 14 help of three) assist. Denies any needs @ this time..." Observation of the resident on February 27, at 9:21 a.m., and on February 28, 2012, at 8:54 a.m., in the common area, revealed the resident was sitting up in a wheelchair with a personal safety alarm in place and turned on. Review of a facility investigation dated December 28, 2011, at 8:55 p.m., revealed "...Alarm found off..." Review of a statement given by a Certified Nursing Assistant (CNA) #2 dated December 28, 2011, revealed, "...Called to room by CNA. Observed resident sitting in floor beside bed. Alarms not sounding..." Review of a statement by RN #1 dated December 28, 2011, "...Responded to code yellow to room...Resident was lying in floor beside of bed. Alarm was not turned on..." Interview with the Fall and Accident Coordinator on February 29, 2012, at 9:55 a.m., in the executive conference room, confirmed the personal safety alarm had not been turned on at the time of the fall on December 28, 2011. Resident #11 was admitted to the facility on January 17, 2012, with diagnoses including Muscle Weakness, Paralysis Agitans (Parkinson's Disease), Congestive Heart Failure, Generalized Anxiety Disorder, Anemia, Cardiac Pacemaker, and Vascular Dementia. Observation on February 28, 2012, at 9:55 a.m.,	F 323		

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F 323	Continued From page 15 in front of the 300-400 Hall Nurse's Desk, revealed the resident in the wheelchair with a self release seat belt on and a Personal Safety Alarm (PSA) in place on the back of the wheel chair. Observation and interview with Unit Manager #3 on February 28, 2012, in front of the 300-400 Nurse's Desk, at 10:00 a.m., confirmed the PSA was not turned on and not functioning to alarm if the resident attempted to get out of the wheelchair unassisted.	F 323		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to respond timely to a - - - pharmacist consultant recommendation for one resident (#10) of thirty residents reviewed The findings included: Resident #10 was admitted to the facility on December 22, 2008, with diagnoses including Mood Disorder, Depression Disorder, Senile	F 428	1. Resident # 10 who was noted during survey to not have his Pharmacist Consultant Recommendation for GDR (Gradual Dose Reduction) Report reviewed by the physician in February 2012, had this report reviewed and signed on 2/29/12 by the facility's Medical Director. 2. The Pharmacist Recommendation (GDR) reports for the prior two months on all other residents were also reviewed and signed by the facility Medical Director. Ongoing, these reports will be dated and signed as to their arrival date at the facility, then reviewed and signed by the Medical Director within 14 days of their arrival. It will be at the Medical Director's discretion to change or not change medication dosages per the recommendation of the Pharmacist Recommendation (GDR) report. Cont.	April 9, 2012

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F 428	Continued From page 16 Dementia and Psychotic Disorder with Delusions Medical record review of a Drug Regimen Review dated August 18, 2011, revealed "...Patient has been taking Paroxetine (anti-depressant) 5mg (milligrams) Q day (every day) since 1/09...D/C Paroxetine..." Further review of the Drug Regimen Review revealed the Physician agreed with the recommendation on September 19, 2011. Medical record review of a Physician's Order dated September 20, 2011, revealed "D/C Paroxetine." Medical record review of the Medication Administration Record (MAR)for September 2011, revealed the medication was administered September 19 and 20, 2011. Interview with Unit Manager 5 on February 29, 2012, at 8:25 a.m., on the 500 hall, confirmed the Physician did not respond to the Pharmacist recommendation dated August 18, 2011 until September 19, 2011 (thirty-two days).	F 428	Cont. 3. A systematic approach to ensure that all Pharmacist Recommendation (GDR) reports for all residents will be reviewed in a timely manner will be accomplished with the implementation of a monthly review log which will be kept by the Physician Liaison Nurse and monitored by the Director of Nursing or his/her designee. The facility Medical Director, Physician Liaison, Director of Nursing and Administrator will be given an in-service education by the contracting Pharmacist on the information and usage of the Pharmacist Recommendation (GDR) report. Cont. SEE ATTACHMENT	April 9, 2012
F 431 SS=F	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be	F 431	1. The Medication Carts (100, 200, 300, 400, and 500 Halls) which were noted to not have completed shift to shift Narcotic Medication reconciliation, narcotic reconciliation for individual resident's (#26, #27 and #28) Controlled Substance Records, proper dating for opened medications (100, 200, 300 and 400 Hall medications carts) , failed provision of expiration dates for emergency medication kits (STAT boxes-100, 200 and 500 Halls), medication lists for contents for emergency medication kit (500 Hall) and appropriate Cont.	April 9, 2012

F Tag 428 cont.

4. Monitoring to ensure that the Pharmacist Recommendation (GDR) report is being reviewed by the facility Medical Director will be done on a monthly basis by the Physician Liaison Nurse and/or Director of Nursing and will be reported for compliance at the monthly Quality Assurance meeting.

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F 431	Continued From page 17 labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single-unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, review of manufacturer's specifications, review of facility's policy, and interview the facility: Failed to provide shift to shift narcotic reconciliation on two (100 Hall Cart, 200 Hall Cart) of six medication carts observed and failed to provide completed shift to shift narcotic reconciliation records on four (300 Hall Cart, 400 Hall Cart, 500 Long Hall Cart, 500 Short Hall Cart) of six medication carts observed.	F 431	cont. accessory instructions on pharmacy prescription labels (100, , 200, 300, 400, and 500 Hall Medication carts) were corrected and completed on 2/29/12 2. In the facility, all other shift to shift Narcotic Medication reconciliation logs, narcotic reconciliation for individual resident's controlled substance records, proper dating of opened medications, expiration dates for emergency medication (STAT boxes), medication lists for contents of emergency medication kits and appropriated accessory instructions on pharmacy prescription labels in the medication carts for the facility where audited to ensure completeness and compliance with current accepted professional principles and State and Federal Laws. 3. A systematic approach to ensure that all shift to shift Narcotic Medication reconciliation logs, narcotic reconciliation for individual resident's controlled substance records, proper dating of opened medications, expiration dates for emergency medication (STAT boxes), medication lists for contents of emergency medication kits and appropriated accessory instructions on pharmacy prescription labels in the medication carts for the facility will be audited on a weekly basis by the Medication Nurse, Unit Manager or Quality Assurance Nurse to ensure completeness and compliance with current accepted professional principles and State and Federal Laws. Results of this audit will be logged on a Medication Review Audit tool. All Medication Nurses, Unit Managers and Quality Assurance Nurses will have in-service education on correct medication management in compliance Cont.	April 9, 2012

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F 431	Continued From page 18 Failed to provide narcotic reconciliation on three Individual Resident's Controlled Substance Records (#26, #27, #28) of forty-one observed on one medication cart (200 Hall Cart) of six medication carts observed. Failed to provide proper dating for opened medications on four (100 Hall Cart, 200 Hall Cart, 300 Hall Cart, 400 Hall Cart) of six medication carts observed. Failed to provide expiration dates for five emergency medication kits (Stat Box 133, Stat Box 120, Stat Box M-14, Stat Box 329, White Emergency Cart on wheels) of five emergency kits observed in two (100-200 Hall Medication Room, 500 Hall Medication Room) of three medication rooms observed and failed to provide a medication list for one emergency medication kit (Stat Box 329) of five emergency kits observed on one (500 Hall Medication Room) of three medication rooms observed. Failed to provide appropriate accessory instructions on pharmacy prescription labels for five (100 Hall Cart, 200 Hall Cart, 300 Hall Cart, 400 Hall Cart, 500 Long Hall Cart) of six medication carts observed. The findings included: Narcotic Reconciliation Shift to Shift Lorazepam Injection Observation of the refrigerator on February 27, 2012, at 5:50 a.m., in the 100-200 Hall Medication Room with Licensed Practical Nurse	F 431	cont. with current accepted professional principles and State and Federal Laws. 4. Monitoring to ensure medications are managed in the facility per current accepted professional principles and State and Federal Laws will be accomplished by auditing with the Medication Review audit and compliance monitored by the Quality Assurance Nurse who will report results at the monthly Quality Assurance meeting.	

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F 431	Continued From page 19 (LPN) #1 revealed one Lorazepam 2 milligram (mg) per 1 milliliter (ml) vial without a pharmacy prescription label. Lorazepam is an injectable controlled medication with anti-anxiety, sedative, and anticonvulsant effects. Medical record review of the Individual Resident's Controlled Substance Records on the 200 Hall Medication Cart on February 27, 2012, at 6:00 a.m., at the 100-200 Hall Nursing Station with LPN #1 revealed the absence of an Individual Resident's Controlled Substance Record for the Lorazepam 2 mg vial. Further medical record review of the Individual Resident's Controlled Substance Records on the 100 Hall Medication Cart revealed the absence of a record for the Lorazepam 2 mg vial. Review of the facility's policy, "Controlled Medications" revealed, "...6. Medication Record Keeping...b. At the time of delivery, the licensed nurse accepting the medication will complete the Individual Resident's Controlled Substance Record or, in the event that a medication is being obtained to supplement the facility's emergency drug supply, the licensed nurse will complete the Narcotic Inventory Check list form...d. A count of all Controlled medications will be done at the end of each shift by the on-coming licensed nurse and the off-going licensed nurse. The physical inventory count of each Controlled medication will be documented on the Narcotic Inventory Check List by the licensed nurses. e. Any discrepancy in controlled substance medication count will be reported immediately to the Director of Nursing. The DON, or designee, will Immediately investigate and make every reasonable effort to reconcile all reported discrepancies..."	F 431		

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F 431	Continued From page 20 Interview with LPN #1 on February 27, 2012, at 6:05 a.m., at the 100-200 Hall Nursing Station confirmed there was not an Individual Resident's Controlled Substance Record on the 100 Hall Medication Cart or the 200 Hall Medication Cart for shift to shift reconciliation for the Lorazepam 2 mg vial. Interview with the 100 Hall Unit Manager and the 200 Hall Unit Manager on February 27, 2012, at 11:50 a.m., at the 100-200 Hall Nursing Station confirmed controlled substances are to be counted and reconciled shift to shift by the on-coming and off-going nurse comparing the Individual Resident's Controlled Substance Record with the actual count and were not aware the Lorazepam injection in the refrigerator on the 100-200 Hall Nursing Station was not being reconciled shift to shift. Interview with the Director of Nursing (DON) and the Consultant Pharmacist (by telephone) on February 28, 2012, at 3:00 p.m., in the Executive Conference Room confirmed all controlled substances are to be counted and reconciled shift to shift per facility's policy and were not aware the Lorazepam injection in the refrigerator on the 100-200 Hall Medication Room was not being reconciled. 200 Hall Cart Individual Resident's Controlled Substance Records Medical record review during a control substance audit on February 27, 2012, between 6:55 a.m. and 7:10 a.m., at the 200 Hall Medication Cart on the 100-200 Hall Nursing Station with LPN #1	F 431		

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F 431	Continued From page 21 revealed an Individual Resident's Controlled Substance Record for Hydrocodone 2.5 mg with Acetaminophen 500 mg tablet (medication for pain) for Resident #26. Further audit revealed a discrepancy in the record. The recorded count on the Individual Resident's Controlled Substance Record was 6 tablets and the physical count was 7 tablets. Interview with LPN #1 on February 27, 2012, at 7:15 a.m., at the 200 Hall Medication Cart at the 100-200 Hall Nursing Station confirmed the discrepancy. When LPN #1 was asked why there was a discrepancy, LPN #1 responded, "I signed out the 6 a.m. dose but did not give it". When LPN #1 was asked if LPN #1 had signed the dose as given on the Individual Resident's Controlled Substance Record, LPN #1 responded, "Yes." Medical record review during a control substance audit on February 27, 2012, between 6:55 a.m. and 7:10 a.m., at the 200 Hall Medication Cart on the 100-200 Hall Nursing Station with LPN #1 revealed an Individual Resident's Controlled Substance Record for Lorazepam 2 mg tablet (medication for agitation) for Resident #27. Further audit revealed a discrepancy in the record. The recorded count on the Individual Resident's Controlled Substance Record was 20 tablets and the physical count was 21 tablets. Interview with LPN #1 on February 27, 2012, at 7:15 a.m., at the 200 Hall Medication Cart on the 100-200 Hall Nursing Station confirmed the discrepancy. When LPN #1 was asked why there was a discrepancy, LPN #1 responded, "I signed out the 6 a.m. dose but did not give it". When LPN #1 was asked if LPN #1 had signed the dose	F 431		

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F 431	Continued From page 22 as given on the Individual Resident's Controlled Substance Record, LPN #1 responded, "Yes." Medical record review during a control substance audit on February 27, 2012, between 6:55 a.m. and 7:10 a.m., at the 200 Hall Medication Cart on the 100-200 Hall Nursing Station with LPN #1 revealed an Individual Resident's Controlled Substance Record for Hydrocodone 10 mg with Acetaminophen 500 mg tablet (medication for pain) for Resident #28. Further audit revealed a discrepancy in the record. The recorded count on the Individual Resident's Controlled Substance Record was 29 tablets and the physical count was 30 tablets. Interview with LPN #1 on February 27, 2012, at 7:15 a.m., at the 200 Hall Medication Cart at the 100-200 Hall Nursing Station confirmed the discrepancy. When LPN #1 was asked why there was a discrepancy, LPN #1 responded, "I signed out the 6 a.m. dose but did not give it". When LPN #1 was asked if LPN #1 had signed the dose as given on the Individual Resident's Controlled Substance Record, LPN #1 responded, "Yes." Interview with the DON and the Consultant Pharmacist (by telephone) on February 28, 2012, at 3:00 p.m., in the Executive Conference Room confirmed all controlled substances are to be counted and reconciled shift to shift per facility's policy and were not aware all controlled medications were not being reconciled on the 200 Hall Cart. Shift to Shift Narcotic Count Records Medical record review on the 100 Hall Medication	F 431		

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F 431	Continued From page 23 Cart on February 27, 2012, at 11:40 a.m., at the 100-200 Hall Nursing Station of the February 2012 Narcotic Control Record for shift to shift documentation of nursing signatures revealed the absence of 104 nursing signatures documenting reconciliation out of 104 nursing signature opportunities for the first twenty-six days in February 2012. Interview with LPN #4 on February 27, 2012, at 11:45 a.m., at the 100 Hall Medication Cart on the 100-200 Hall Nursing Station confirmed there was not a shift to shift reconciliation sheet for controlled medications for the 100 Hall Cart for the month of February 2012. When the surveyor asked LPN #4 why the shift to shift reconciliation sheet was not signed by LPN #4 at shift change, LPN #4 responded, "There was no sheet available to sign." Interview with the 100 Hall Unit Manager and the 200 Hall Unit Manager on February 27, 2012, at 11:50 a.m., at the 100-200 Hall Nursing Station confirmed controlled substances are to be counted and reconciled shift to shift by the on-coming and off-going nurse comparing the Individual Resident's Controlled Substance Record with the actual count and all controlled medications were not being reconciled on the 100 Hall Cart for February 2012. Medical record review on the 200 Hall Medication Cart on February 27, 2012, at 6:30 a.m., at the 100-200 Hall Nursing Station of the February 2012 Narcotic Control Record for shift to shift documentation of nursing signatures revealed the absence of 104 nursing signatures documenting reconciliation out of 104 nursing signature	F 431		

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F 431	Continued From page 24 opportunities for the first twenty-six days in February 2012. Interview with LPN #1 on February 27, 2012, at 6:35 a.m., at the 100-200 Hall Nursing Station confirmed there was not a shift to shift reconciliation sheet for Controlled medications for the 200 Hall Cart for the month of February 2012. When LPN #1 was asked why LPN #1 had not signed the shift to shift reconciliation record, LPN #1 responded, "There was no sheet available to sign." Interview with the 100 Hall Unit Manager and the 200 Hall Unit Manager on February 27, 2012, at 11:50 a.m., at the 100-200 Hall Nursing Station confirmed controlled substances are to be counted and reconciled shift to shift by the on-coming and off-going nurse comparing the Individual Resident's Controlled Substance Record with the actual count and all controlled medications were not being reconciled on the 200 Hall Cart for February 2012. Medical record review on the 300 Hall Medication Cart on February 28, 2012, at 9:30 a.m., at the 300-400 Hall Nursing Station of the February 2012 Narcotic Control Record for shift to shift documentation of nursing signatures revealed the absence of 20 nursing signatures documenting reconciliation out of 104 nursing signature opportunities for the first twenty-six days in February 2012. Medical record review on the 400 Hall Medication Cart on February 28, 2012, at 10:00 a.m., at the 300-400 Hall Nursing Station of the February 2012 Narcotic Control Record for shift to shift	F 431		

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F 431	Continued From page 25 documentation of nursing signatures revealed the absence of 14 nursing signatures documenting reconciliation out of 104 nursing signature opportunities for the first twenty-six days in February 2012. Medical record review of the 500 Short Hall Medication Cart on February 28, 2012, at 10:25 a.m., at the 500 Hall Nursing Station of the February 2012 Narcotic Control Record for shift to shift documentation of nursing signatures revealed the absence of 38 nursing signatures documenting reconciliation out of 104 nursing signature opportunities for the first twenty-six days in February 2012. Medical record review on the 500 Long Hall Medication Cart on February 27, 2012, at 1:55 p.m., at the 500 Hall Nursing Station of the February 2012 Narcotic Control Record for shift to shift documentation of nursing signatures revealed the absence of 21 nursing signatures documenting reconciliation out of 104 nursing signature opportunities for the first twenty-six days in February 2012. Interview with the DON and the Consultant Pharmacist (by telephone) on February 28, 2012, at 3:00 p.m., in the Executive Conference Room confirmed all controlled substances are to be counted and reconciled shift to shift per facility's policy and were not aware all controlled medications were not being reconciled shift to shift on the 100 Hall, 200 Hall, 300 Hall, 400 Hall, 500 Long Hall, and 500 Short Hall medication carts. Expiration Dates	F 431		

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F 431	Continued From page 26 Observation of one medication cart (200 Hall Cart) on February 27, 2012, at 6:15 a.m., with LPN #1 revealed one opened 2.5 ml bottle of Latanoprost (medication for glaucoma) Sterile Ophthalmic 0.005% Solution. Review of the manufacturer's specification on the outside of the Latanoprost box revealed, "...Opened bottles may be stored at room temperature...for 6 weeks..." Observation of four medication carts-(100 Hall Cart, 200 Hall Cart, 300 Hall Cart, 400 Hall Cart) between February 27, 2012, at 6:15 a.m. and February 28, 2012 at 10:25 a.m., with the following LPNs (LPN #4, LPN #1, LPN #8, LPN #6) revealed 3 boxes of MediSense Glucose Control Solutions (solutions for testing blood sugar for diabetics) with the expired dating of 9-16-11, 10-11-11, and 9-22-11 and one box of MediSense Glucose Control Solutions that was not dated when opened. Review of the manufacturer's specifications in the package insert for MediSense Solutions revealed solutions "are stable for 90 days after opening". Observation of the 200 Hall Cart between February 27, 2012, at 6:15 a.m. and February 28, 2012 at 10:25 a.m., with LPN #1 revealed one opened Advair Diskus containing Fluticasone 250 micrograms (mcg) and Salmeterol 50 mcg (medication for asthma) with the following label, "DISCARD UNUSED PORTION after the expiration date of 2/9/12" and one Advair Diskus without the date opened.	F 431		

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F 431	Continued From page 27 Review of the manufacturer's specification in the package insert for Advair Discus revealed, "...discard ADVAIR DISKUS 1 month after you remove it from the foil pouch..." Interview with the DON and the Consultant Pharmacist (by telephone) on February 28, 2012, at 3:00 p.m., in the Executive Conference Room confirmed the Advair Diskus is not to be administered past the expiration date and is to be marked with an expiration date when opened. Observation of the 100-200 Hall Medication Room on February 27, 2012, at 5:50 a.m., with LPN #1 revealed one emergency medication kit (Stat Box 133) without an expiration date on the outside of the box. Observation of the 500 Hall Medication Room on February 27, 2012, at 1:55 p.m., with LPN #5 revealed four emergency medication kits (Stat Box 120, Stat Box M-14, Stat Box 329, White Emergency Cart on wheels) without an expiration date on the outside of each box. Further observation revealed the outside of Stat Box 329 did not have a list of contents on the box. Review of the Tennessee Pharmacy Laws 2011 Edition Rule 1140-4-.09 Emergency and Home Care Kits documented "...(3) The expiration date of the kit shall be clearly marked on the exterior of the kit to represent the earliest expiration date of any drug, device, or related materials contained in the kits...6. A list of the emergency kit contents shall be readily accessible and it shall include the drugs, device, and related materials contained therein and include the name (trade and/or generic), strength, and quantity of the	F 431		

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F 431	Continued From page 28 products contained therein..." Interview with the DON and the Consultant Pharmacist (by telephone) on February 28, 2012, at 3:00 p.m., in the Executive Conference Room confirmed emergency medication kits are to marked with an expiration date on the exterior of the kit and a list of the contents is to be readily accessible. Appropriate Accessory Instructions Observation of the 100 Hall Medication Room on February 27, 2012, at 11:40 a.m., with LPN #4 revealed one sixteen ounce bottle of Sodium Polystyrene Sulfonate (medication to reduce Potassium) without a "shake well" label. Review of the manufacturer's specification in the package insert for Sodium Polystyrene Sulfonate revealed, "...SHAKE WELL..." Observation of five medication carts (100 Hall Cart, 200 Hall Cart, 300 Hall Cart, 400 Hall Cart, 500 Long Hall Cart) between February 27, 2012, at 6:15 a.m. and February 28, 2012 at 10:25 a.m., with the following LPNs (LPN #4, LPN #1, LPN #8, LPN #6, LPN #5,) revealed 10 bottles of 120 doses each of Fluticasone Nasal Spray (medication for rhinitis) without a "Shake Well" label. Further review revealed the pharmacy label covered the manufacturer's "Shake Well" label. Review of the manufacturer's specification in the package insert for Fluticasone Nasal Spray revealed, "...Shake gently before using..."	F 431		

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F 431	Continued From page 29 Interview with the DON and the Consultant Pharmacist (by telephone) on February 28, 2012, at 3:00 p.m., in the Executive Conference Room confirmed "shake well" labels are to be affixed to medications that require shaking prior to administration.	F 431		
F 502 SS=D	483.75(j)(1) ADMINISTRATION The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on medical record review, and interview, the facility failed to obtain laboratory tests timely for one resident (#13) of thirty residents reviewed. The findings included: Resident #13 was admitted to the facility on January 24, 2012, with diagnoses including Brain Stem Cerebrovascular Accident, Respiratory Failure, and Diabetes Mellitus. Medical record review of a Physician's Order dated January 30, 2012, revealed "...labs to be drawn on February 20, 2012: CMP (complete metabolic panel), prealbumin (blood test for measuring protein deficiency)..." Medical record review revealed no documentation the labs were obtained. Interview with Unit Clerk #1 on February 27, 2012, at 2:18 p.m., at the 500 Hall Nurses	F 502	1. Resident #13 who had a physician order to have a CMP and prealbumin lab drawn on 2/20/12 but it was not drawn, had this physician order discontinued and reordered on 2/28/12. This re-ordered lab was drawn on the same day of this new order. 2. All other residents in the facility with lab orders where audited on 2/29/12 to ensure that all labs were drawn on the day designated by the physician order. 3. A systematic approach to ensure that all residents who have labs ordered to be drawn on a specific day will have their labs entered on to a Lab Log which will be monitored for correct draw date by the Lab Draw Coordinator. All Labs to be drawn will be audited on a weekly basis per a Lab Audit Log for compliance ensuring that the correct draw date has been accomplished. All Unit Managers will have an in-service education on notifying the Lab Draw Coordinator of the ordered Lab so it can be placed on the Lab Log to ensure the correct draw date has occurred. 4. Monitoring to ensure that all Labs are drawn on the designated draw date per physician order will be accomplished by auditing the Lab Log by the Lab Draw Coordinator who will report results at the monthly at the Quality Assurance meeting.	April 9, 2012

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F 502	Continued From page 30 Station, confirmed the resident's CMP and prealbumin was due on February 20, 2012, and the facility failed to obtain the laboratory tests.	F 502		
F 514 SS=E	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to ensure the medical record accurately documented the code status for one resident (#9) and failed to ensure accurate documentation on Medication Administration Records (MAR) for three residents (#8, #10, #21) of thirty residents reviewed. The findings included: Resident #9 was admitted to the facility on July 28, 2009, with diagnosis of Dysphagia, UTI, Vascular Dementia with Delusions, Depressed Mood, Pain in Soft Tissues of Limb, Dementia with Behavioral Disturbances, General Anxiety	F 514	1. Resident #9 who was identified during survey as not having their Code Status updated, had this document updated and placed in her Medical Record on 2/29/12 , Residents #8, #10, and #21 who had Medications administered but not documented on their MAR, had these records reviewed 2/29/12 for completion and accuracy. 2. All other residents in the facility had their Code Status reviewed and updated (if needed) for completion and accuracy in their Medical Record. All residents in the facility also had their MAR reviewed for completion and accuracy. 3. A systematic approach to ensure that all residents have their Code Status complete and accurate in their Medical Record will be accomplished by a monthly audit by the Unit Manager, Social Service Staff or Quality Assurance Nurse and documented on a Code Status audit log. All residents will have their Medication Administration Records (MARS) complete and accurate which will be accomplished by a daily audit by the Unit Manager, House SV or Quality Assurance Nurse on an audit log. The Quality Assurance Nurses, Unit Managers, Social Services Staff and Nursing SV's will be educated on the need to make sure that all Code Status for the residents are complete and accurate on the chart. The Medication Nurses, Unit Managers, Quality Assurance Nurse and Nursing SV's will be in-serviced on the need to ensure that all MARS are complete and accurate for Mediation Administration. Cont.	April 9, 2012

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F 514	Continued From page 31 Disorder, Senile Dementia, Mood Disorder, Diabetes Type II, Gout, Anxiety, Hypoxemia, Down's Syndrome. Medical record review of a Physicians Orders for the Scope of Treatment (POST) form dated July 29, 2009, revealed the resident was a full code. Medical record review of a Request For Do Not Resuscitate Order and a Do Not Resuscitate (DNR) Order dated November 3, 2010, revealed the resident was a DNR. Review of the Medication Administration Record (MAR) for February 2012, revealed, "Code Status: Full Code." Medical Record Review of the Physician's Recapitulation orders signed by the physician February 10, 2012, indicated the resident was a full code since August 1, 2011. Medical record review of a POST form which had not been signed and dated by the Physician indicated the resident was a DNR. Interview with LPN unit manager #4 on February 28, 2012, at 9:55 a.m., at the 400 hall nurse's station, confirmed the resident was a DNR and the medical record did not accurately reflect the resident's code status. Resident #8 was admitted to the facility on November 15, 2011, with diagnoses including Vascular Dementia with Depressed Mood and Delusions, Paralysis Agitans, Atrial Fibrillation, Dementia with Behavior Disturbance, Diabetes, Chronic Obstructive Pulmonary Disease,	F 514	cont. 4. Monitoring for completion and accuracy of all Code Status and Mars will be monitored per the Code Status or MAR Audit Log by the Quality Assurance Nurse and compliance reported monthly at the Quality Assurance meeting.	

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F 514	Continued From page 32 Obstructive Sleep Apnea, Hypertension, Morbid Obesity, and Long-term Anticoagulants. Medical record review of the Medication Administration Record (MAR) for the month of January 2012 revealed the following missing documentation for medication administration: Risperdal (antipsychotic) January 22, 23, 24, 26; Flomax (urinary retention) January 22, 23, 26, 29, 30; Namenda (dementia) January 30; Amlodipine (blood pressure) January 30; Allopurinol (gout) January 30; Aspirin January 30; Celexa (antidepressant) January 30; Digoxin (irregular heartbeat) January 30; Exelon (Alzheimers) January 30; Metformin (Diabetes) January 30; Humalog (Insulin) two times on January 30; Sinemet (Parkinson's) January 30; and Depakote (antiseizure) January 30. Interview with Unit Manager #4 on February 29, 2012, at 8:00 a.m., in the common room, confirmed the MAR had not been documented to indicate medications had been administered. Telephone interview with LPN #14 on February 29, 2012, at 8:15 a.m., confirmed "100 percent sure" gave the resident the scheduled medications, however, "forgot to sign off" medications as being given on January 30, 2012 on the MAR. Resident #10 was admitted to the facility on December 22, 2008, with diagnoses including Mood Disorder, Depression Disorder, Senile Dementia and Psychotic Disorder with Delusions. Medical record review of the MAR for January, 2012, revealed the resident was to receive	F 514		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445207	A. BUILDING _____ B. WING _____	02/29/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEXFORD HOUSE, THE	2421 JOHN B DENNIS HIGHWAY KINGSPORT, TN 37660

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F 514	Continued From page 33 Paroxetine HCL (anti-depressant) at 8:00 a.m., Aspirin at 9:00 a.m., "AZO"(brand name) Cranberry with Probiotic with Vitamin C" at 9:00 a.m., Losartan Potassium (anti-hypertensive) at 9:00 a.m., Nitrofurantoin (antibiotic) at 9:00 a.m., Vitamin B-12 at 9:00 a.m., Calcitrate plus D (calcium) at 9:00 a.m., Deep Sea Nasal Spray (saline) at 8:00 a.m., 12:00 p.m., and 4:00 p.m., and Vitamin D at 9:00 a.m. Further medical record review of the MAR revealed the medications had not been signed as administered January 30, 2012. Interview with unit manager #4 on February 29, 2012, at 8:05 a.m., at the 400 nursing station, confirmed the MAR had not been documented to indicate the medications were given. Telephone interview with Licensed Practical Nurse (LPN) #13 on February 29, 2012, at 8:20 a.m., confirmed the LPN administered the medications but failed to document the MAR. Resident #21 was admitted to the facility on December 27, 2007, with diagnoses including Multiple Sclerosis, Diabetes Mellitus, Deep Vein Thrombosis, Peripheral Artery Disease, and Osteomyelitis. Medical record review of a Medication - Administration Record (MAR) dated January 1, 2012 thru January 31, 2012, revealed the resident was to receive the following medications; Lyrica (medication for pain control) at 2 p.m., on January 1 and 2, and at 10 p.m., on January 6; Ambien (insomnia medication) at 9 p.m., on January 6 and 20; Rocephin (antibiotic) at 10 a.m., on January 6; Coumadin (blood thinner) at 6 p.m., on	F 514		

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F 514	Continued From page 34 January 6; Bactrim DS (antibiotic) at 8 p.m., on January 20; and Copaxone (medication for Multiple Sclerosis) at 6 p.m., on January 1, 2, 3, 15, 16, 19, 27, and 29. Further review of the MAR revealed the medications had not been signed as administered. Medical record review of a MAR dated February 1, 2012 thru February 29, 2012, revealed the resident was to receive the following medications; Copaxone at 6 p.m., on February 23 and 24; Lasix (medication for fluid retention) at 9 a.m., on February 22; K-Dur (medication for low potassium) at 6:30 a.m., on February 18; Cubicin (antibacterial) at 9 a.m., on February 22; Cymbalta (medication for depression) at 9 a.m., on February 22; Bentyl (medication for irritable bowel) at 9 a.m., on February 22; and Fibercon (medication for constipation) at 9 a.m., on February 22. Further medical record review of the MAR revealed the medications had not been signed as administered. Interview with Unit Manager #4 on February 29, 2012, at 10:50 a.m., at the 400 hall nurses station confirmed the MAR for January 2012 and February 2012 did not document the administration of medications.	F 514		